CORRESPONDENCE

Pediatric anesthesia: pre-empt to save the life

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Dear Editor,

The common causes of laryngospasm after tracheal extubation, in pediatric population, include mild pre-existing upper respiratory infection, secretions, blood, noxious stimuli in a light plane of anesthesia etc. The patients desaturate rapidly during laryngospasm, which if not treated promptly, results in bradycardia and even cardiac arrest.[1,2]

We report a 3 year old child, weighing 15 kg who underwent cataract surgery under general anaesthesia. The induction of anaesthesia and intra-operative period were uneventful. The residual neuromuscular blockade was reversed and oropharyngeal suctioning was done before extubation. Immediately after extubation, patient had severe laryngospasm which did not respond to institution of oxygen flush. The peripheral arterial oxygen saturation started decreasing. Immediately atropine 0.3 mg was given as a preemptive measure against bradycardia. It was difficult to ventilate the patient, so 3 mg succinylcholine was given intravenously and trachea was reintubated. At this moment the pulse oximetry showed peripheral arterial oxygen saturation 2% with heart rate of 180 min^{-1}. Within seconds oxygen saturation improved to 100% and after 15 minutes, trachea was reextubated which was uneventful.

Management of laryngospasm involves removal of the irritant stimulus, jaw thrust, administration of 100% oxygen and increasing the depth of sedation by sub hypnotic dose of propofol (0.8 mg/kg). However, suxamethonium remains the gold standard for treatment of laryngospasm.[2] With this case we want to highlight that it is better to manage one problem (desaturation) rather than two problems (desaturation and bradycardia) simultaneously. Administration of atropine was used as a preemptive measure against expected bradycardia. Though heart rate would have improved with improvement in oxygen saturation but administration of atropine prevented bradycardia.

REFERENCES

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